Family PACT
Planning • Access • Care • Treatment
OFFICE OF FAMILY PLANNING
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Provider Orientation & Update Training
Registration Form
June 21, 2006 – DHS Auditorium
1500 Capitol Ave, Sacramento, CA 95814

Please Complete and FAX to 916 650-0468

If you are attending for more than one provider number, you must complete a separate registration form for each provider number. If your information is not current with the Medi-Cal Provider Master File, you need to notify Medi-Cal Provider Enrollment Branch immediately. For more information, go to www.Medi-Cal.ca.gov

NOTE: If you indicate on Line 5 below that you are requesting a Certificate of Attendance, please note that individual and group providers wishing to enroll in Family PACT must send a physician-owner to this session. Clinics requesting to enroll must send the medical director or practitioner responsible for oversight of medical services rendered in connection with the Medi-Cal provider number. Other staff may attend but they will not be issued a Certificate.

1. **Legal Business Name:** Indicate the legal name of the business as listed on file with Medi-Cal.
2. **Medi-Cal Provider Number:** Indicate the Medi-Cal number for the business represented today (Medi-Cal billing number).
3. **Service Site Information (Address, Phone Number & Contact Information):** Indicate the address where Family PACT services will be rendered as listed on file with Medi-Cal. Please include city, state, zip and county. Indicate the phone number for the service site and provide a contact phone number if different. Indicate the FAX number you wish to have confirmation of registration faxed to.
4. **Request for Certificate of Attendance:** If requesting a Certificate, check "yes" and refer to instructions for Item #6.
5. **Person(s) Attending: List all participants attending this session and their title, starting with practitioner authorized to receive Certificate. If not requesting a Certificate, write "N/A" on first line.** Then list all other participants. Use a second page for additional names.

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PLEASE PRINT CLEARLY

1. **Legal Business Name (as listed on file with Medi-Cal)**: _____

2. **Medi-Cal Provider Number (Medi-Cal billing number):** _____

3 **Service Site Information (as listed on file with Medi-Cal):**

_____
(Service Site Address Number and Street Name)

_____ _____
(City, State, Zip) **(County)**

Service Site Phone: _____
Contact Name: _____
Contact Phone: _____
FAX number: _____
Email: _____

4. **Requesting Certificate of Attendance? (Mark with an "X")** **YES____** **NO____** (If 'NO,' write N/A on Line #1 below)

5. **Names of Person(s) Attending:** **Title:** (MD, NP, Office Manger, etc.)

1) _____ _____
(Practitioner authorized to receive Certificate of Attendance)

2) _____ _____

3) _____ _____

4) _____ _____

For Dept of Health Services Family PACT staff use only: **Date/Time/Initial** _____ ☐ FAX back ☐ Email

☐ Confirmed reservation for _____ persons.

☐ Additional information needed. Please call Family PACT at 1-877-FamPACT.

☐ Training reached maximum allowed participants. Please go to www.familypact.org to see next scheduled session.

☐ Other: _____

Certificate of Attendance #: _____ Date Issued: _____

(Rev. 2/24/2006)